DEPARTMENT OF THE ARMY
NONAPPROPRIATED FUNDS

CERTIFICATE OF MEDICAL EXAMINATION

(Applicant must supply information below to heavy line)

(Typewrite or Print in Ink)

For use of this form, see AR 215-3; the proponent agency is DCS, G1.

1. NAME *(CAPS)* LAST - FIRST - MIDDLE MR. - MISS - MRS.	2. SEX ☐ MALE ☐ FEMALE	3. BIRTH DATE *(Mo., day, year)*
4. STREET ADDRESS AND APARTMENT NO.	5. CITY, STATE, AND ZIP CODE	

6. POSITION TITLE AND NUMBER	7. PAY PLAN AND OCCUPATION CODE	8. GRADE OR LEVEL	9. SALARY

10. NAME AND LOCATION OF EMPLOYING OFFICE

11. (A) ARE YOU NOW EMPLOYED IN POSITION SHOWN IN ITEM 7 ☐ YES ☐ NO	(B) IF "YES" GIVE THE DATE OF YOUR ORIGINAL APPOINTMENT TO THIS POSITION:

13. (A) HAVE YOU ANY PHYSICAL DEFECT OR DISABILITY WHATSOEVER? ☐ YES ☐ NO IF "YES", GIVE DETAILS.

(B) DOES THE VETERANS ADMINISTRATION RECOGNIZE SERVICE-CONNECTED DISABILITY IN YOUR CASE? ☐ YES ☐ NO

(C) HAVE YOU EVER RECEIVED DISABILITY RETIREMENT FROM THE U.S. CIVIL SERVICE COMMISSION OR A NONAPPROPRIATED FUND ACTIVITY? ☐ YES ☐ NO

Sign your name in INK as it appears on your application in the presence of the physician for purpose of identification.	

DOCTOR: All questions on both sides of this certificate and on the lower half of the attached Health Qualification Placement Record must be answered. Before beginning the examination, refer to items 13 and 14 on the Health Qualification Placement Record so that you will have a knowledge of the physical requirements of the position to which the applicant is to be appointed. Sign both this certificate and the Health Qualification Placement Record

1. HEIGHT:_____ FEET_____INCHES WEIGHT:_____POUNDS

2. EYES: 20 20 20 20

(A) DISTANT VISION *(Snellen):* WITHOUT GLASSES: RIGHT LEFT WITH GLASSES, IF WORN: RIGHT LEFT

(B) WHAT IS THE LONGEST AND SHORTEST DISTANCE AT WHICH THE FOLLOWING SPECIMEN OF JAEGER NO. 2 TYPE CAN BE READ BY THE APPLICANT? TEST EACH EYE SEPARATELY.

	WITHOUT GLASSES:	WITH GLASSES, IF WORN:
	R. _____ IN. TO _____ IN.	R. _____ IN. TO _____ IN.
	L. _____ IN. TO _____ IN.	L. _____ IN. TO _____ IN.

(C) EVIDENCE OF DISEASE OR INJURY: RIGHT_____ LEFT _____

(D) COLOR VISION: IS COLOR VISION NORMAL WHEN ISHIHARA OR OTHER COLOR PLATE TEST IS USED? ☐ YES ☐ NO

IF NOT, CAN APPLICANT PASS LANTERN, YARN, OR OTHER COMPARABLE TEST? ☐ YES ☐ NO

3. EARS: (CONSIDER DENOMINATORS INDICATED HERE AS NORMAL. RECORD AS NUMERATORS THE GREATEST DISTANCE HEARD) ORDINARY CONVERSATION:

RIGHT EAR_____ 20 FT. LEFT EAR_____ 20 FT. EVIDENCE OF DISEASE OR INJURY: RIGHT EAR ☐ LEFT EAR ☐

4. NOSE	5. PARA NASAL SINUSES	6. MOUTH AND THROAT

7. GASTRO-INTESTINAL

(A) HISTORY OF PEPTIC ULCER: ☐ YES ☐ NO IF "YES", IS ULCER: ☐ ACTIVE ☐ QUIESCENT ☐ HEALED

HOW LONG?_____ DATE OF LAST X-RAY_____

SYMPTOMS PRESENT, IF ANY *(Severity, frequency, etc.):*

TREATMENT *(Use space under "Remarks," if needed):*

8. METABOLIC DISORDERS: (INDICATE ANY ABNORMALITY OF THE FOLLOWING GLANDS BY A CHECK IN THE APPROPRIATE BOX, AND EXPLAIN UNDER "REMARKS.")

☐ THYROID ☐ PANCREAS ☐ PITUITARY ☐ OVARIAN

9. HEART AND BLOOD VESSELS

(A) BLOOD PRESSURE: MM. HG. SYSTOLIC _____ DIASTOLIC

(B) IS ORGANIC HEART DISEASE PRESENT? ☐ YES ☐ NO

(C) IF ORGANIC HEART DISEASE IS PRESENT, IS IT FULLY COMPENSATED? ☐ YES ☐ NO

(D) PULSE RATE:
SITTING _____ IMMEDIATELY AFTER EXERCISE (UNLESS CONTRAINDICATED) _____
TWO MINUTES AFTER EXERCISE _____ CARDIAC RESERVE _____
(GOOD, FAIR, OR POOR)

10. LUNGS:

RIGHT _____ LEFT _____

HISTORY OF TUBERCULOSIS? ☐ YES ☐ NO. IF "YES", HOW LONG HAS THE DISEASE BEEN ARRESTED? _____

IF THERE IS HISTORY OF TUBERCULOSIS, IS ANY TYPE OF COLLAPSE THERAPY BEING RECEIVED AT PRESENT? ☐ YES ☐ NO. IF "YES," GIVE FULL DETAILS UNDER "REMARKS." IS MEDICAL SUPERVISION NECESSARY? ☐ YES ☐ NO

(IF X-RAY IS MADE, GIVE REPORT UNDER "REMARKS.")

11. HERNIA: ☐ YES ☐ NO. IF "YES", NAME VARIETY: INGUINAL, VENTRAL, FEMORAL, POST-OPERATIVE, ETC.: _____

IF PRESENT, IS IT SUPPORTED BY A WELL-FITTING TRUSS? ☐ YES ☐ NO

12. VARICOSE VEINS: ☐ YES ☐ NO. IF "YES", STATE LOCATION AND DEGREE.

13. FEET: IS FLAT FOOT PRESENT? ☐ YES ☐ NO. IF "YES", STATE DEGREE OF IMPAIRMENT OF FUNCTION _____
(NONE, SLIGHT, MODERATE, SEVERE)

14. DEFORMITIES, ATROPHIES, AND OTHER ABNORMALITIES, DISEASE NOT INCLUDED ABOVE

15. SCARS OF SERIOUS INJURY OR DISEASE

16. NERVOUS SYSTEM: (A) INCLUDE SYMPTOMS AND FULL HISTORY OF ANY MENTAL, NERVOUS OR EMOTIONAL ABNORMALITY (USE ADDITIONAL SHEETS IF NECESSARY.):

(B) HAS APPLICANT EVER BEEN HOSPITALIZED OR TREATED FOR A MENTAL ILLNESS? ☐ YES ☐ NO

(C) WHERE (NAME AND LOCATION OF HOSPITAL):

(D) DATE OR DATES OF HOSPITALIZATION:

(E) DESCRIBE ANY RESIDUALS OF PREVIOUS MENTAL OR NERVOUS ILLNESS:

(F) ANY HISTORY OF EPILEPSY OR FAINTING SPELLS? ☐ YES ☐ NO. IF SO, GIVE DETAILS UNDER "REMARKS" BELOW.

17. EVIDENCE OR HISTORY OF VENEREAL DISEASE: IF BLOOD SEROLOGY OR OTHER LABORATORY EXAMINATIONS ARE MADE, GIVE DETAILS UNDER "REMARKS."

18. URINALYSIS (IF INDICATED):
SP. GR _____ ALBUMEN _____ SUGAR _____
CASTS _____ BLOOD _____ PUS _____

I HAVE FOUND THE APPLICANT ABNORMAL UNDER THE FOLLOWING HEADINGS:

REMARKS:

19. SIGNATURE OF PHYSICIAN OR EXAMINER	NAME TYPED OR PRINTED	DATE

20. ADDRESS OF EXAMINING PHYSICIAN *(Typed or printed)*

21. DO YOU HAVE FEDERAL DESIGNATION? ☐ YES ☐ NO
IF "YES," SPECIFY

☐ FULL TIME ☐ PART TIME ☐ FEE BASIS

HEALTH QUALIFICATION PLACEMENT RECORD
(NONAPPROPRIATED FUNDS)

1. NAME *(CAPS)* LAST - FIRST - MIDDLE MR. - MISS - MRS.	2. SEX ☐ MALE ☐ FEMALE	3. BIRTH DATE *(Mo., day, year)*
5. STREET ADDRESS AND APARTMENT NO.	6. CITY, STATE, AND ZIP CODE	

7. POSITION TITLE AND NUMBER	8. PAY PLAN AND OCCUPATION CODE	9. GRADE OR LEVEL	10. SALARY

11. NAME AND LOCATION OF EMPLOYING OFFICE	
12. (A) ARE YOU NOW EMPLOYED IN POSITION SHOWN IN ITEM 7 ☐ YES ☐ NO	(B) IF "YES" GIVE THE DATE OF YOUR ORIGINAL APPOINTMENT TO THIS POSITION:

TO BE COMPLETED BY APPOINTING OFFICER: SECTIONS 13 AND 14

(A). BRIEF OUTLINE OF WHAT WORKER DOES	(B). PHYSICAL DEMANDS OF THE POSITION
For the physician's use, set down in brief and simple terms what the employee does on this job, including environmental details such as stairs to climb, distance to rest room facilities, cafeteria, workshift, etc. *(Use Section 13 below.)*	In Section 14 below, encircle the number of those factors which are essential to the duties of the position for which this applicant is being considered. The blank spaces may be used for special factors not listed.

13. TITLE OF POSITION AND OUTLINE OF WHAT WORKER DOES IN THIS POSITION *(Advise use of dictionary of occupational titles as guide, as applicable)*

TO BE COMPLETED BY EXAMINING PHYSICIAN: SECTIONS 14 THROUGH 20

INSTRUCTIONS: The items circled below indicate the physical requirements of the position for which this individual is being considered. Indicate the individual's physical capacities for this position by placing an X in the appropriate column opposite the numbers encircled. If the individual has any other physical limitations relating to physical requirements not encircled or not covered by this form, indicate these under **"Remarks"** on the reverse side. Whenever PARTIAL capacity has been indicated, explain under **"Remarks,"** giving specific quantities.

14. PHYSICAL REQUIREMENTS

	CAPACITY		
	FULL	PARTIAL	NONE
1. OUTSIDE			
2. OUTSIDE AND INSIDE			
3. EXCESSIVE HEAT			
4. EXCESSIVE COLD			
5. EXCESSIVE HUMIDITY			
6. EXCESSIVE DAMPNESS OR CHILLING			
7. DRY ATMOSPHERIC CONDITIONS			
8. EXCESSIVE NOISE, INTERMITTENT			
9. CONSTANT NOISE			
10. DUST			
11. SILICA, ASBESTOS, ETC.			
12. FUMES, SMOKE, OR GASES			
13. SOLVENTS *(Degreasing agents)*			
14. GREASES AND OILS			
15. RADIANT ENERGY			
16. ELECTRICAL ENERGY			
17. SLIPPERY OR UNEVEN WALKING SURFACES			

ENVIRONMENTAL FACTORS

	CAPACITY		
	FULL	PARTIAL	NONE
18. WORKING AROUND MACHINERY WITH MOVING PARTS			
19. MOVING OBJECTS OR VEHICLES			
20. WORKING ON LADDERS OR SCAFFOLDING			
21. WORKING BELOW GROUND			
22. UNUSUAL FATIGUE FACTORS *(Specify)*	☐	☐	☐
23. WORKING WITH HANDS IN WATER			
24. EXPLOSIVES			
25. VIBRATION			
26. WORKING CLOSELY WITH OTHERS			
27. WORKS ALONE			
28. PROTRACTED OR IRREGULAR HOURS OF WORK			
29. SPECIAL FACTORS *(Specify)*	☐	☐	☐

14. PHYSICAL REQUIREMENTS (Continued) — FUNCTIONAL FACTORS

	CAPACITY		
	FULL	PARTIAL	NONE
33. HEAVY LIFTING - 45 POUNDS AND OVER			
34. MODERATE LIFTING - 15-44 POUNDS			
35. LIGHT LIFTING - UNDER 15 POUNDS			
36. HEAVY CARRYING - 45 POUNDS AND OVER			
37. MODERATE CARRYING - 15-44 POUNDS			
38. LIGHT CARRYING - UNDER 15 POUNDS			
39. STRAIGHT PULLING (HOURS)			
40. PULLING - HAND OVER HAND (HOURS)			
41. PUSHING (HOURS)			
42. REACHING ABOVE SHOULDER			
43. USE OF FINGERS			
44. BOTH HANDS REQUIRED			
45. WALKING (HOURS)			
46. STANDING (HOURS)			
47. CRAWLING (HOURS)			
48. KNEELING (HOURS)			
49. REPEATED BENDING (HOURS)			
50. CLIMBING - LEGS ONLY (HOURS)			
51. CLIMBING - USE OF LEGS AND ARMS			
52. BOTH LEGS REQUIRED			
53. OPERATION OF CRANE, TRUCK, TUG, TRACTOR, OR MOTOR VEHICLE			

	CAPACITY		
	FULL	PARTIAL	NONE
54. ABILITY FOR RAPID MENTAL AND MUSCULAR COORDINATION SIMULTANEOUSLY			
55. ABILITY TO USE AND DESIRABILITY OF USING FIREARMS			
56. NEAR VISION CORRECTIBLE AT 13 TO 16 INCHES TO *(Jaeger 1 to 4)*			
57. FAR VISION CORRECTIBLE TO 20/20 TO 20/40			
58. FAR VISION CORRECTIBLE TO 20/50 TO 20/100			
59. SPECIFIC VISUAL REQUIREMENT *(Specify)*			
60. BOTH EYES REQUIRED			
61. DEPTH PERCEPTION			
62. ABILITY TO DISTINGUISH BASIC COLORS			
63. ABILITY TO DISTINGUISH SHADES OF COLORS			
64. HEARING *(Aid permitted)*			
65. HEARING WITHOUT AID			
66. SPECIFIC HEARING REQUIREMENTS *(Specify)*			
67.			
68.			
69.			
70.			

15. THIS PERSON SHOULD USE: (A) PROPERLY FITTED EYEGLASSES ☐ **(B) PROPERLY FITTED HEARING AID** ☐
(C) OTHER PROSTHETIC AID *(Specify)* ☐

16. REMARKS AND RECOMMENDATIONS:

17. PHYSICAL HANDICAP CODE

18. SIGNATURE OF PHYSICIAN OR EXAMINER	**NAME TYPED OR PRINTED**	**DATE**

19. ADDRESS OF EXAMINING PHYSICIAN *(Typed or printed)*

20. DO YOU HAVE FEDERAL DESIGNATION? ☐ **YES** ☐ **NO**
IF "YES," SPECIFY

☐ **FULL TIME** ☐ **PART TIME** ☐ **FEE BASIS**

TO BE COMPLETED BY SUPERVISOR

21. POSITION TO WHICH INDIVIDUAL WAS ASSIGNED

22. SIGNATURE OF SUPERVISOR	**NAME TYPED OR PRINTED**	**DATE**

PHYSICAL HANDICAP CODE INSTRUCTIONS

If the person examined has or has had a handicap which is listed on the back of these instructions, enter the code number in Item No. 17 on the Health Qualification Placement Record.

If more than one handicap applies, enter the one you think most limiting. If none of the handicaps apply, enter the code "00."

Detach these instructions after entering Physical Handicap Code on the Health Qualification Placement Record.

PHYSICAL HANDICAP CODE

00	**NO REPORTABLE HANDICAP**
10	**AMPUTATION - ONE EXTREMITY**
11	**AMPUTATION - TWO OR MORE EXTREMITIES**
20	**DEFORMITY OR IMPAIRED FUNCTION - UPPER EXTREMITY**
21	**DEFORMITY OR IMPAIRED FUNCTION - LOWER EXTREMITY OR BACK**
30	**VISION - BEST CORRECTED VISION OF POORER EYE NOT MORE THAN 20/200**
31	**VISION - BEST CORRECTED VISION OF BETTER EYE NOT MORE THAN 20/200**
40	**HEARING - SOME IN ONE EAR, NONE IN OTHER**
41	**HEARING - IN BOTH EARS BUT NOT MORE THAN 12/20 IN BETTER EAR WITHOUT USE OF A HEARING AID**
42	**HEARING - O/20 IN EACH EAR, INCLUDING SPEECH MALFUNCTION**
50	**TUBERCULOSIS - INACTIVE PULMONARY**
51	**ORGANIC HEART DISEASE** *(Compensated)* **VALVULAR, ARRHYTHMIA, ARTERIOSCLEROSIS, HEALED CORONARY LESIONS**
52	**DIABETES - CONTROLLED**
53	**EPILEPSY - ADEQUATELY CONTROLLED**
54	**HISTORY OF EMOTIONAL OR BEHAVIORAL PROBLEMS REQUIRING SPECIAL PLACEMENT EFFORT**
55	**MENTALLY RETARDED** *(Diagnosis must be certified by appropriate State Office of Vocational Rehabilitation)*